Sec. 601 Treatment of prescription drugs procured by the Department of Veterans Affairs or purchased by certain clinics and hospitals

Section 601, effective January 1, 1993:

- Excludes from manufacturer's "best price" consideration, prices of drugs charged under the Federal Supply Schedule, prices used under a State pharmaceutical assistance program, and prices charged on or after October 1, 1992, to the VA, State veterans' homes, the Department of Defense, the Indian Health Service, the Public Health Service (PHS), or covered entities as defined in Section 602;

- Makes Medicaid drug payment contingent on manufacturer price agreements with the DVA and PHS, and requires the Secretary to establish a mechanism to ensure against duplicate discounts and Medicaid rebates.

- Amends the rebate formula to maintain budget neutrality; and

- Requires a report to Congress, on the top 1,000 drugs receiving federal Medicaid payments, on changes in best price, expenditures, and total rebates attributable to basic, additional, and flat rebates.

Sec. 602 Limitations on prices of drugs purchased by certain clinics and hospitals

Section 602, effective on enactment, adds subpart VII, Drug Pricing Agreements, to Part D of title III of the Public Health Service Act that:

- Requires The Secretary of HHS to enter into agreements with manufacturers limiting the payment for covered drugs purchased by covered entities to no more than the average manufacturers' price (AMP) for the drug under Medicaid minus the rebate percentage. The rebate percentage for over-the-counter drugs is to be determined as it is for generic drugs.

- Covered entities are prohibited from requesting duplicate discounts or reselling drugs covered under a pricing agreement.

- Covered entities subject to these provisions are: federally qualified health centers, health services for residents of public housing grantees, family planning projects, HIV early intervention grantees, State-operated AIDS drug purchasing assistance programs, black lung clinics, comprehensive hemophilia diagnostic centers, native Hawaiian health centers, urban Indian organizations, certain disproportionate share hospitals, and certain other entities as certified by the Secretary, DHHS.

- The Secretary of HHS must notify manufacturers and Medicaid agencies both of the identity of covered entities and of those that are no longer certified.

- The Secretary of HHS must conduct and report after one year on the feasibility and desirability of including entities receiving funds for mental health or substance abuse treatment services or outpatient maternal and child health services as covered entities.

Sec. 603 Limitation on prices of drugs procured by Department of Veterans Affairs and certain other Federal agencies

Section 603, effective January 1, 1993:

- Denies payment by Medicaid, VA, DoD, PHS, or any entity that receives funds under the PHS Act for the drugs of manufacturers who do not have a master agreement with DVA in effect by January 1, 1993, except those drugs that are essential or subject to prior authorization. The master agreement puts the drugs of a manufacturer on the Federal Supply Schedule and has a pricing agreement for FSS and depot drugs.

- The Secretary of DVA must provide to the Secretary of HHS, the names of manufacturers that enter into and terminate master agreements.

- Under the agreements, the prices charged during the first year may not exceed 76 percent of the non-Federal AMP less the amount of any additional discount due because of price increases in excess of CPI-U.

- "Depot" means a centralized commodity management system through which covered drugs are procured by an agency of the Federal government and delivered to the provider.

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